

*Michigan Department
of Community Health*



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**2010–2011 EXTERNAL QUALITY REVIEW
TECHNICAL REPORT**
for
Medicaid Health Plans

March 2012



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Purpose of Report

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with the Code of Federal Regulations (CFR), 42 CFR 438.358, were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the states' managed care organizations, called Medicaid Health Plans (MHPs) in Michigan. The report of results must also contain an assessment of the strengths and weaknesses of the plans regarding health care quality, timeliness, and access, and must make recommendations for improvement. Finally, the report must assess the degree to which the MHPs addressed any previous recommendations. To meet this requirement, the State of Michigan Department of Community Health (MDCH) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to aggregate and analyze MHP data and prepare the annual technical report.

The State of Michigan contracted with the following MHPs represented in this report:

- ◆ **BlueCaid of Michigan (BCD)**
- ◆ **CareSource Michigan (CSM)**
- ◆ **Health Plan of Michigan, Inc. (HPM)**
- ◆ **HealthPlus Partners (HPP)**
- ◆ **McLaren Health Plan (MCL)**
- ◆ **Midwest Health Plan (MID)**
- ◆ **Molina Healthcare of Michigan (MOL)**
- ◆ **OmniCare Health Plan (OCH)**
- ◆ **Physicians Health Plan of Mid-Michigan Family Care (PMD)**
- ◆ **Priority Health Government Programs, Inc. (PRI)**
- ◆ **ProCare Health Plan (PRO)**
- ◆ **Total Health Care, Inc. (THC)**
- ◆ **UnitedHealthcare Great Lakes Health Plan, Inc. (GLH)**
- ◆ **Upper Peninsula Health Plan (UPP)**

Scope of External Quality Review (EQR) Activities Conducted

This EQR technical report analyzes and aggregates data from three mandatory EQR activities:

- ◆ **Compliance Monitoring:** MDCH evaluated the MHPs' compliance with federal Medicaid managed care regulations using a compliance review process. HSAG examined, compiled, and analyzed the results as presented in the MHP compliance review documentation provided by MDCH.
- ◆ **Validation of Performance Measures:** Each MHP underwent a National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Audit™ conducted by an NCQA-licensed audit organization. HSAG performed an independent audit of the audit findings to determine the validity of each performance measure.
- ◆ **Validation of Performance Improvement Projects (PIPs):** HSAG reviewed one PIP for each MHP to ensure that the projects were designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported improvements.

Summary of Findings

The following is a statewide summary of the conclusions drawn regarding the MHPs' general performance in 2010–2011. Appendices A–N contain detailed, MHP-specific findings, while Section 3 presents detailed statewide findings with year-to-year comparisons.

Compliance Review

MDCH continued its process of compliance reviews for the MHPs, assessing compliance with State, federal, and contractual requirements related to the following six standards: *Administrative; Provider; Member; Quality/Utilization; MIS/Data Reporting/Claims Processing; and Fraud, Waste, and Abuse*. MDCH conducted a follow-up review of its contracted MHPs, assessing their progress in addressing recommendations from the 2009–2010 annual compliance reviews as well as their performance related to a set of mandatory criteria for review in each of the six standards, regardless of the MHP's prior performance.

The MHPs implemented corrective actions to address prior-year recommendations and demonstrated compliance with most of the criteria that were assessed during the 2010–2011 compliance reviews. MHP performance ranged from about half of the criteria to almost all criteria receiving a score of *Pass*. Statewide opportunities for improvement continued to exist for the *Quality/Utilization* and *Fraud, Waste, and Abuse* standards.

Validation of Performance Measures

Table 1-1 displays the 2011 Michigan Medicaid weighted averages and performance levels. The performance levels are a comparison of the 2011 Michigan Medicaid weighted average and the NCQA national HEDIS 2010 Medicaid percentiles. For most measures, a display of ★★★★★ indicates performance at or above the 90th percentile. Performance levels displayed as ★★★★ represent performance at or above the 75th percentile but below the 90th percentile. A ★★★ performance level indicates performance at or above the 50th percentile but below the 75th percentile. Performance levels displayed as ★★ represent performance at or above the 25th percentile but below the 50th percentile. Finally, performance levels displayed as a ★ indicate that the weighted average performance was below the 25th percentile.

For inverse measures, such as *Comprehensive Diabetes Care—Poor HbA1c Control*, the 25th percentile (rather than the 90th percentile) represents excellent performance and the 90th percentile (rather than the 25th percentile) represents below-average performance. For *Ambulatory Care* measures, since high/low visit counts reported did not take into account the demographic and clinical conditions of an eligible population, performance levels do not necessarily denote better or worse performance.

All 14 of the MHPs demonstrated the ability to calculate and report accurate performance measures specified by the State and were fully compliant with the information system (IS) standards related to the measures required to be reported by MDCH.

Table 1-1—Overall Statewide Weighted Averages for Performance Measures

Performance Measure	2011 MI Medicaid	Performance Level for 2011
Pediatric and Adolescent Care		
<i>Childhood Immunization Status—Combination 2</i>	78.2%	★★★
<i>Childhood Immunization Status—Combination 3</i>	74.3%	★★★
<i>Immunizations for Adolescents</i>	52.9%	★★★
<i>Lead Screening in Children</i>	78.0%	★★★
<i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>	72.3%	★★★★
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	78.0%	★★★★
<i>Adolescent Well-Care Visits</i>	58.8%	★★★★
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment, 3 to 11 Years</i>	45.7%	★★★★
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment, 12 to 17 Years</i>	48.2%	★★★★
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment, Total</i>	46.6%	★★★★
<i>Appropriate Treatment for Children With Upper Respiratory Infection (URI)</i>	84.9%	★★
<i>Appropriate Testing for Children With Pharyngitis</i>	54.9%	★★
★★★★★ = 90th percentile and above ★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile		

Table 1-1—Overall Statewide Weighted Averages for Performance Measures

Performance Measure	2011 MI Medicaid	Performance Level for 2011
Women’s and Adult Care		
<i>Breast Cancer Screening</i>	56.3%	★★★
<i>Cervical Cancer Screening</i>	74.3%	★★★★
<i>Chlamydia Screening in Women—16 to 20 Years</i>	60.7%	★★★
<i>Chlamydia Screening in Women—21 to 24 Years</i>	68.4%	★★★
<i>Chlamydia Screening in Women—Combined</i>	63.5%	★★★
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	88.4%	★★★
<i>Prenatal and Postpartum Care—Postpartum Care</i>	70.7%	★★★★
<i>Adult BMI Assessment</i>	63.0%	★★★★★
Living With Illness		
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	85.0%	★★★
<i>Comprehensive Diabetes Care—Poor HbA1c Control*</i>	36.4%	★★★
<i>Comprehensive Diabetes Care—Eye Exam</i>	59.0%	★★★
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	80.8%	★★★★
<i>Comprehensive Diabetes Care—LDL-C Level <100 mg/dL</i>	41.1%	★★★★
<i>Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy</i>	82.8%	★★★★
<i>Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg[^]</i>	40.8%	†
<i>Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg</i>	63.7%	★★★
<i>Use of Appropriate Medications for People With Asthma—5 to 11 Years</i>	91.4%	★★
<i>Use of Appropriate Medications for People With Asthma—12 to 50 Years</i>	85.2%	★★
<i>Use of Appropriate Medications for People With Asthma—Combined Rate</i>	87.4%	★★
<i>Controlling High Blood Pressure</i>	61.5%	★★★
<i>Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers to Quit</i>	78.2%	❖
<i>Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications</i>	48.8%	❖
<i>Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies</i>	41.3%	❖

* For this measure, a lower rate indicates better performance.

[^] During HEDIS 2011, this indicator was changed from *Blood Pressure Control <130/80* to *Blood Pressure Control <140/80*.

† Due to changes to the measure specifications for this indicator, national benchmarks are not available for this measurement period.

❖ These measures are CAHPS measures; therefore, no HEDIS benchmarks are available.

- ★★★★★ = 90th percentile and above
- ★★★★ = 75th to 89th percentile
- ★★★ = 50th to 74th percentile
- ★★ = 25th to 49th percentile
- ★ = Below 25th percentile

Table 1-1—Overall Statewide Weighted Averages for Performance Measures

Performance Measure	2011 MI Medicaid	Performance Level for 2011
Access to Care		
<i>Children’s Access to Primary Care Practitioners—12 to 24 Months</i>	96.7%	☆☆
<i>Children’s Access to Primary Care Practitioners—25 Months to 6 Years</i>	89.8%	★★★★
<i>Children’s Access to Primary Care Practitioners—7 to 11 Years</i>	91.1%	☆☆
<i>Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i>	89.5%	★★★★
<i>Adults’ Access to Preventive/Ambulatory Health Services—20 to 44 Years</i>	83.2%	★★★★
<i>Adults’ Access to Preventive/Ambulatory Health Services—45 to 64 Years</i>	89.1%	★★★★
<i>Adults’ Access to Preventive/Ambulatory Health Services—65+ Years</i>	89.1%	★★★★
<i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i>	85.0%	★★★★
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months⁺</i>	316.9	★
<i>Ambulatory Care—ED Visits per 1,000 Member Months⁺</i>	69.6	★★★★
⁺ For Ambulatory Care measures, the statewide rates represent straight averages, not weighted averages.		
★★★★★ = 90th percentile and above ★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile		

Of the 41 performance measures that had national results available for comparison, 26.8 percent (11 measures) showed performance that fell between the 75th and 89th percentile. 51.2 percent (21 measures) performed at or above the 50th percentile but below the 75th percentile. Only 19.5 percent (8 measures) performed below the national HEDIS 2010 Medicaid 50th percentile, which included one measure (*Ambulatory Care—Outpatient Visits per 1,000 Member Months*) performing below the 25th percentile. One measure, *Adult BMI Assessment*, performed at or above the 90th percentile.

Performance Improvement Projects (PIPs)

For the 2010–2011 validation cycle, MDCH selected a new State-mandated PIP topic, *Childhood Obesity*. The primary goal of the PIPs was to increase the documentation rate of body mass index (BMI) percentiles for members 3 to 17 years of age. Several MHPs included additional study indicators related to increasing the rate for counseling for nutrition and physical activity. All 14 MHPs received a validation status of *Met* for their PIPs, as shown in Table 1-2.

Validation Status	Number of MHPs
<i>Met</i>	14
<i>Partially Met</i>	0
<i>Not Met</i>	0

Table 1-3 presents a summary of the statewide 2010–2011 results of the validation of the ten activities of the protocol for validating PIPs. HSAG validated all 14 PIPs for Activities I through VIII. Twelve of the 14 PIPs demonstrated compliance with all evaluation elements, including critical elements, for the activities that were validated. The MHPs demonstrated strong performance related to the quality of their studies and a thorough application of the requirements for Activities I through VIII of the CMS protocol for conducting PIPs.

Review Activities		Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	Number of PIPs Meeting All Critical Elements/ Number Reviewed
I.	Select the Study Topic(s)	14/14	14/14
II.	Define the Study Question(s)	14/14	14/14
III.	Select the Study Indicator(s)	14/14	14/14
IV.	Use a Representative and Generalizable Study Population	14/14	14/14
V.	Use Sound Sampling Techniques*	11/12	12/12
VI.	Reliably Collect Data	13/14	14/14
VII.	Analyze Data and Interpret Study Results	13/14	14/14
VIII.	Implement Intervention and Improvement Strategies	14/14	14/14
IX.	Assess for Real Improvement	0/0	No Critical Elements
X.	Assess for Sustained Improvement	0/0	No Critical Elements

* This activity is assessed only for PIPs that conduct sampling.

Quality, Timeliness, and Access

The annual compliance review of the MHPs showed strong performance across the domains of **quality, timeliness, and access**. The MHP implemented corrective actions to address opportunities for improvement identified in the previous review cycle.

The validation of the MHPs' PIPs reflected strong performance in the **quality** domain. All projects were designed, conducted, and reported in a methodologically sound manner, giving confidence in the reported results.

Forty-one of the 45 performance measures were compared with the available national Medicaid HEDIS percentiles. Overall, results of validated performance measures were average across the **quality, timeliness, and access** domains.

Table 1-4 shows HSAG's assignment of the compliance review standards, performance measures, and PIPs into the domains of **quality, timeliness, and access**.

Table 1-4—Assignment of Activities to Performance Domains

Compliance Review Standards	Quality	Timeliness	Access
Standard 1. <i>Administrative</i>	✓		
Standard 2. <i>Provider</i>	✓	✓	✓
Standard 3. <i>Member</i>	✓	✓	✓
Standard 4. <i>Quality/Utilization</i>	✓		✓
Standard 5. <i>MIS/Data Reporting/Claims Processing</i>	✓	✓	
Standard 6. <i>Fraud, Waste, and Abuse</i>	✓	✓	✓
Performance Measures	Quality	Timeliness	Access
<i>Childhood Immunization Status</i>	✓	✓	
<i>Immunizations for Adolescents</i>	✓	✓	
<i>Lead Screening in Children</i>	✓	✓	
<i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>	✓		
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	✓		
<i>Adolescent Well-Care Visits</i>	✓		
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment</i>	✓		
<i>Appropriate Treatment for Children With Upper Respiratory Infection (URI)</i>	✓		
<i>Appropriate Testing for Children With Pharyngitis</i>	✓		
<i>Breast Cancer Screening</i>	✓		
<i>Cervical Cancer Screening</i>	✓		
<i>Chlamydia Screening in Women</i>	✓		
<i>Prenatal and Postpartum Care</i>		✓	✓
<i>Adult BMI Assessment</i>	✓		
<i>Comprehensive Diabetes Care</i>	✓		
<i>Use of Appropriate Medications for People With Asthma</i>	✓		
<i>Controlling High Blood Pressure</i>	✓		
<i>Medical Assistance With Smoking and Tobacco Use Cessation</i>	✓		
<i>Children’s and Adolescents’ Access to Primary Care Practitioners</i>			✓
<i>Adults’ Access to Preventive/Ambulatory Health Services</i>			✓
<i>Ambulatory Care</i>			✓
PIPs	Quality	Timeliness	Access
One PIP for each MHP, Childhood Obesity Topic	✓		

Introduction

This section of the report describes the manner in which data from the activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed.

Compliance Monitoring

Objectives

According to 42 CFR 438.358, a state or its EQRO must conduct a review within a three-year period to determine the Medicaid managed care organizations' compliance with standards established by the state for access to care, structure and operations, and quality measurement and improvement. To meet this requirement, MDCH performed compliance reviews of its MHPs.

The objectives of evaluating contractual compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and to assist the MHPs in developing corrective actions to achieve compliance with the contractual requirements.

Technical Methods of Data Collection

MDCH was responsible for the activities that assessed MHP compliance with federal Medicaid managed care regulations. For the 2010–2011 compliance reviews, MDCH focused on those criteria for which the MHP had received a score of *Incomplete* or *Fail* during the prior-year review. MDCH also assessed the MHPs' compliance with some criteria in each of the standards that were considered mandatory for review regardless of the MHP's prior performance.

Description of Data Obtained

To assess the MHPs' compliance with federal and State requirements, MDCH obtained information from a wide range of written documents produced by the MHPs, including the following:

- ◆ Policies and procedures
- ◆ Current quality assessment and performance improvement (QAPI) programs
- ◆ Minutes of meetings of the governing body, quality improvement (QI) committee, compliance committee, utilization management (UM) committee, credentialing committee, and peer review committee
- ◆ QI work plans, utilization reports, provider and member profiling reports, QI effectiveness reports
- ◆ Internal auditing/monitoring plans, auditing/monitoring findings

- ◆ Claims review reports, prior-authorization reports, complaint logs, grievance logs, telephone contact logs, disenrollment logs, MDCH hearing requests, medical record review reports
- ◆ Provider service and delegation agreements and contracts
- ◆ Provider files, disclosure statements, current sanctioned/suspended provider lists
- ◆ Organizational charts
- ◆ Fraud, waste, and abuse logs; fraud, waste, and abuse reports
- ◆ Employee handbooks, fliers, employee newsletters, provider manuals, provider newsletters, Web sites, educational/training materials, and sign-in sheets
- ◆ Member materials, including welcome letters, member handbooks, member newsletters, provider directories, and certificates of coverage
- ◆ Provider manuals

For the 2010–2011 compliance reviews, MDCH continued to use its automated tool in an Access database application. Prior to the scheduled compliance review, each MHP received the tool with instructions for entering the required information. For each criterion, the Access application specified which supporting documents were required for submission, stated the previous score, and provided a space for the MHP’s response. Following the compliance review, MDCH completed the section for State findings and assigned a score for each criterion. The tool was also used for the MHP to describe, after the compliance review, any required corrective action plan and to document MDCH’s action plan assessment. MDCH summarized each of the MHPs’ focus studies in a focus study report.

Data Aggregation, Analysis, and How Conclusions Were Drawn

MDCH reviewers used the compliance review tool for each MHP to document their findings and to identify, when applicable, specific action(s) required of the plan to address any areas of noncompliance with contractual requirements.

For each criterion reviewed, MDCH assigned one of the following scores:

- ◆ *Pass*—The MHP demonstrated full compliance with the requirement(s).
- ◆ *Incomplete*—The MHP demonstrated partial compliance with the requirement(s).
- ◆ *Fail*—The MHP failed to demonstrate compliance with the requirement(s).

For the current review cycle, only a subset of the criteria was included in the review; and the criteria assessed by MDCH varied among the MHPs. Therefore, HSAG could not calculate a total compliance score for each standard or an overall score for each MHP across all six standards.

To draw conclusions and make overall assessments about the **quality** and **timeliness** of, and **access** to, care provided by the MHPs using findings from the compliance reviews, the standards were categorized to evaluate each of these three domains. Using this framework, Table 1-4 (page 1-9) shows HSAG’s assignment of standards to the three domains of performance.

Validation of Performance Measures

Objectives

As set forth in 42 CFR 438.358, validation of performance measures is one of the mandatory EQR activities. The primary objectives of the performance measure validation process are to:

- ◆ Evaluate the accuracy of the performance measure data collected by the MHP.
- ◆ Determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure.

To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess each MHP's support system available to report accurate HEDIS measures.

Technical Methods of Data Collection and Analysis

MDCH required each MHP to collect and report a set of Medicaid HEDIS measures. Developed and maintained by NCQA, HEDIS is a set of performance measures broadly accepted in the managed care environment as an industry standard.

Each MHP underwent an NCQA HEDIS Compliance Audit conducted by an NCQA-licensed audit organization. The NCQA HEDIS Compliance Audit followed NCQA audit methodology as set out in NCQA's 2011 *HEDIS Compliance Audit: Standards, Policies, and Procedures*. The NCQA HEDIS Compliance Audit encompasses an in-depth examination of the health plans' processes consistent with CMS' protocols for validation of performance measures. To complete the validation of performance measures process according to the CMS protocols, HSAG performed an independent evaluation of the audit results and findings to determine the validity of each performance measure.

Each HEDIS Compliance Audit, conducted by a licensed audit organization, included the following activities:

Pre-review Activities: Each MHP was required to complete the NCQA Record of Administration, Data Management, and Processes (Roadmap), which is comparable to the Information Systems Capabilities Assessment Tool, Appendix Z of the CMS protocols. Pre-on-site conference calls were held to follow up on any outstanding questions. The audit team conducted a thorough review of the Roadmap and supporting documentation, including an evaluation of processes used for collecting, storing, validating, and reporting the performance measure data.

On-site Review: The on-site reviews, which typically lasted one to two day(s), included:

- ◆ An evaluation of system compliance, focusing on the processing of claims and encounters.
- ◆ An overview of data integration and control procedures, including discussion and observation.

- ◆ A review of how all data sources were combined and the method used to produce the performance measures.
- ◆ Interviews with MHP staff members involved with any aspect of performance measure reporting.
- ◆ A closing conference at which the audit team summarized preliminary findings and recommendations.

Post-on-site Review Activities: For each performance measure calculated and reported by the MHPs, the audit teams aggregated the findings from the pre-on-site and on-site activities to determine whether the reported measures were valid, based on an allowable bias. The audit teams assigned each measure one of four audit findings: (1) *Report* (the rate was valid and below the allowable threshold for bias), (2) *Not Applicable* (the MHP followed the specifications but the denominator was too small to report a valid rate), (3) *No Benefit* (the MHP did not offer the health benefits required by the measure), or (4) *Not Report* (the measure was significantly biased or the plan chose not to report the measure).

Description of Data Obtained

As identified in the CMS protocol, the following key types of data were obtained and reviewed as part of the validation of performance measures. Table 2-1 shows the data sources used in the validation of performance measures and the time period to which the data applied.

Table 2-1—Description of Data Sources	
Data Obtained	Time Period to Which the Data Applied
HEDIS Compliance Audit reports were obtained for each MHP, which included a description of the audit process, the results of the information systems findings, and the final audit designations for each performance measure.	Calendar Year (CY) 2010 (HEDIS 2011)
Performance measure reports, submitted by the MHPs using NCQA’s Interactive Data Submission System (IDSS), were analyzed and subsequently validated by the HSAG validation team.	CY 2010 (HEDIS 2011)
Previous performance measure reports were reviewed to assess trending patterns and the reasonability of rates.	CY 2009 (HEDIS 2010)

Data Aggregation, Analysis, and How Conclusions Were Drawn

HSAG performed a comprehensive review and analysis of the MHPs' IDSS results, data submission tools, and MHP-specific HEDIS Compliance Audit reports and performance measure reports.

HSAG ensured that the following criteria were met prior to accepting any validation results:

- ◆ An NCQA-licensed audit organization completed the audit.
- ◆ An NCQA-certified HEDIS compliance auditor led the audit.
- ◆ The audit scope included all MDCH-selected HEDIS measures.
- ◆ The audit scope focused on the Medicaid product line.
- ◆ Data were submitted via an auditor-locked NCQA IDSS.
- ◆ A final audit opinion, signed by the lead auditor and responsible officer within the licensed organization, was produced.

To draw conclusions and make overall assessments about the **quality** and **timeliness** of, and **access** to, care provided by the MHPs using findings from the validation of performance measures, each measure was categorized to evaluate one or more of the three domains. Table 1-4 (page 1-9) shows HSAG's assignment of performance measures to these domains of performance.

Validation of Performance Improvement Projects (PIPs)

Objectives

As part of its QAPI program, each MHP is required by MDCH to conduct PIPs in accordance with 42 CFR 438.240. The purpose of the PIPs is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. As one of the mandatory EQR activities under the BBA, a state is required to validate the PIPs conducted by its contracted Medicaid managed care organizations. To meet this validation requirement for the MHPs, MDCH contracted with HSAG.

The primary objective of PIP validation was to determine each MHP's compliance with requirements set forth in 42 CFR 438.240(b)(1), including:

- ◆ Measurement of performance using objective quality indicators.
- ◆ Implementation of systematic interventions to achieve improvement in quality.
- ◆ Evaluation of the effectiveness of the interventions.
- ◆ Planning and initiation of activities for increasing or sustaining improvement.

MDCH required that each MHP conduct one PIP subject to validation by HSAG. For the 2010–2011 validation cycle, MDCH selected a new State-mandated PIP topic, *Childhood Obesity*.

Technical Methods of Data Collection and Analysis

The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. The methodology used to validate PIPs was based on guidelines outlined in the CMS publication, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002. Using this protocol, HSAG, in collaboration with MDCH, developed the PIP Summary Form. Each MHP completed this form and submitted it to HSAG for review. The PIP Summary Form standardized the process for submitting information regarding the PIPs and ensured that all CMS PIP protocol requirements were addressed.

HSAG, with MDCH's input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS protocols. The CMS protocols identify ten activities that should be validated for each PIP, although in some cases the PIP may not have progressed to the point at which all of the activities can be validated.

These activities are:

- ◆ Activity I. Select the Study Topic(s)
- ◆ Activity II. Define the Study Question(s)
- ◆ Activity III. Select the Study Indicator(s)

- ◆ Activity IV. Use a Representative and Generalizable Study Population
- ◆ Activity V. Use Sound Sampling Techniques
- ◆ Activity VI. Reliably Collect Data
- ◆ Activity VII. Analyze Data and Interpret Study Results
- ◆ Activity VIII. Implement Intervention and Improvement Strategies
- ◆ Activity IX. Assess for Real Improvement
- ◆ Activity X. Assess for Sustained Improvement

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validations from the MHPs' PIP Summary Form. This form provided detailed information about each MHP's PIP as it related to the ten activities reviewed and evaluated for the 2010–2011 validation cycle.

Data Aggregation, Analysis, and How Conclusions Were Drawn

HSAG used the following methodology to evaluate PIPs conducted by the MHPs to determine if a PIP is valid and to rate the percentage of compliance with CMS' protocol for conducting PIPs.

Each PIP activity consisted of critical and noncritical evaluation elements necessary for successful completion of a valid PIP. Each evaluation element was scored as *Met (M)*, *Partially Met (PM)*, *Not Met (NM)*, *Not Applicable (NA)*, or *Not Assessed*.

The percentage score for all evaluation elements was calculated by dividing the number of elements (including critical elements) *Met* by the sum of evaluation elements *Met*, *Partially Met*, and *Not Met*. The percentage score for critical elements *Met* was calculated by dividing the number of critical elements *Met* by the sum of critical elements *Met*, *Partially Met*, and *Not Met*. The scoring methodology also included the *Not Applicable* designation for situations in which the evaluation element did not apply to the PIP. For example, in Activity V, if the PIP did not use sampling techniques, HSAG would score the evaluation elements in Activity V as *Not Applicable*. HSAG used the *Not Assessed* scoring designation when the PIP had not progressed to the remaining activities in the CMS protocol. HSAG used a *Point of Clarification* when documentation for an evaluation element included the basic components to meet requirements for the evaluation element (as described in the narrative of the PIP), but enhanced documentation would demonstrate a stronger understanding of CMS protocols.

The validation status score was based on the percentage score and whether or not critical elements were *Met*, *Partially Met*, or *Not Met*. Due to the importance of critical elements, any critical element scored as *Not Met* would invalidate a PIP. Critical elements that were *Partially Met* and noncritical elements that were *Partially Met* or *Not Met* would not invalidate the PIP, but they would affect the overall percentage score (which indicates the percentage of the PIP's compliance with CMS' protocol for conducting PIPs).

HSAG assessed the implications of the study's findings on the likely validity and reliability of the results as follows:

- ◆ *Met*: Confidence/high confidence in the reported PIP results.
- ◆ *Partially Met*: Low confidence in the reported PIP results.
- ◆ *Not Met*: Reported PIP results that were not credible.

The MHPs had an opportunity to resubmit revised PIP Summary Forms and additional information in response to any *Partially Met* or *Not Met* evaluation scores, regardless of whether the evaluation element was critical or noncritical. HSAG re-reviewed the resubmitted documents and rescored the PIPs before determining a final score. With MDCH's approval, HSAG offered technical guidance to any MHP that requested an opportunity to review the scoring of the evaluation elements prior to a resubmission. Eleven of the 14 MHPs requested and received technical assistance from HSAG. HSAG conducted conference calls to provide an opportunity for the MHPs to discuss areas of deficiency. HSAG reviewed and discussed each *Point of Clarification* and *Partially Met* or *Not Met* evaluation element, as well as the necessary documentation required to meet the criteria for each activity. HSAG encouraged the MHPs to use the PIP Summary Form Completion Instructions as they completed their PIPs. These instructions outlined each evaluation element and provided documentation resources to support CMS PIP protocol requirements.

HSAG followed the above methodology for validating the PIPs for all MHPs to assess the degree to which the MHPs designed, conducted, and reported their projects in a methodologically sound manner.

After completing the validation review, HSAG prepared a report of its findings and recommendations for each validated PIP. These reports, which complied with 42 CFR 438.364, were forwarded to MDCH and the appropriate MHP.

The EQR activities related to PIPs were designed to evaluate the validity and reliability of the MHP's processes in conducting the PIPs and to draw conclusions about the MHP's performance in the domains of **quality**, **timeliness**, and **access** to care and services. The *Childhood Obesity* PIP addressed CMS' requirements related to quality outcomes—specifically, quality of care and services. The goal of the PIP was to improve the quality of care and services by increasing the rate of body mass index (BMI) documentation for members 3–17 years of age; therefore, HSAG assigned the PIPs to the **quality** domain.

The following section presents findings from the 2010–2011 annual compliance reviews and the EQR activities of validation of performance measures and validation of PIPs for the two reporting periods of 2009–2010 and 2010–2011. Appendices A–N present additional details about the plan-specific results of the activities.

Annual Compliance Review

In 2010–2011, MDCH focused its follow-up compliance review on those criteria where the MHPs received a score of *Incomplete* or *Fail* in the previous year, as well as a set of mandatory criteria for review that were included in the review regardless of the MHPs' prior performance. Because the criteria for which MHPs were required to implement corrective actions were different for each health plan, it was not possible to calculate compliance scores or statewide results.

The 2010–2011 compliance reviews showed that overall, MHPs were successful in addressing the recommendations from the previous review and demonstrated compliance with the requirements. One of the MHPs received a score of *Pass* for about half of the criteria addressed, while the remaining MHPs demonstrated compliance with almost all of the criteria and had continuing recommendations for only a few (ranging from one to four) of the criteria assessed.

The *Quality/Utilization*; *MIS/Data Reporting/Claims Processing*; and *Fraud, Waste, and Abuse* standards represented the greatest opportunities for improvement following the 2009–2010 compliance reviews. While the follow-up review reflected marked improvement in these areas, one of the criteria in each of these standards remained a statewide opportunity for improvement. On the *Quality/Utilization* standards, MHPs should continue their efforts to meet the MDCH performance standard for all measures. For the *MIS/Data Reporting/Claims Processing* standard, timely and complete submission of required reports continued to be an area for improvement; and for the *Fraud, Waste, and Abuse* standard, MHPs should continue their efforts to bring their credentialing and recredentialing processes into full compliance.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process were to evaluate the accuracy of the performance measure data collected by the MHPs and determine the extent to which the specific performance measures calculated by the MHPs (or on behalf of the MHPs) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a thorough information system evaluation was performed to assess the ability of each MHP's support system to report accurate HEDIS measures, as well as a measure-specific review of all reported measures.

Results from the validation of performance measures activities showed that all 14 MHPs received a finding of *Report* (i.e., appropriate processes, procedures, and corresponding documentation) for all assessed performance measures. The performance measure data were collected accurately from a wide variety of sources statewide. All of the MHPs demonstrated the ability to calculate and

accurately report performance measures that complied with HEDIS specifications. This finding suggested that the information systems for reporting HEDIS measures were a statewide strength.

Table 3-1 displays the 2011 Michigan Medicaid weighted averages and performance levels. The performance levels are a comparison of the 2011 Michigan Medicaid weighted average and the NCQA national HEDIS 2010 Medicaid percentiles. For most measures, a display of ★★★★★ indicates performance at or above the 90th percentile. Performance levels displayed as ★★★★ represent performance at or above the 75th percentile but below the 90th percentile. A ★★★ performance level indicates performance at or above the 50th percentile but below the 75th percentile. Performance levels displayed as ★★ represent performance at or above the 25th percentile but below the 50th percentile. Finally, performance levels displayed as a ★ indicate that the weighted average performance was below the 25th percentile.

For inverse measures, such as *Comprehensive Diabetes Care—Poor HbA1c Control*, the 25th percentile (rather than the 90th percentile) represents excellent performance and the 90th percentile (rather than the 25th percentile) represents below-average performance.

For *Ambulatory Care* measures, since high/low visit counts reported did not take into account the demographic and clinical conditions of an eligible population, performance levels do not necessarily denote better or worse performance.

Table 3-1—Overall Statewide Weighted Averages for Performance Measures

Performance Measure	2010 MI Medicaid	2011 MI Medicaid	Performance Level for 2011	2010–2011 Comparison
Pediatric and Adolescent Care				
<i>Childhood Immunization Status—Combination 2</i>	78.7%	78.2%	★★★	-0.5
<i>Childhood Immunization Status—Combination 3</i>	74.0%	74.3%	★★★	+0.3
<i>Immunizations for Adolescents</i>	41.0%	52.9%	★★★	+11.9
<i>Lead Screening in Children</i>	76.5%	78.0%	★★★	+1.5
<i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>	69.5%	72.3%	★★★★	+2.8
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	75.9%	78.0%	★★★★	+2.1
<i>Adolescent Well-Care Visits</i>	56.3%	58.8%	★★★★	+2.5
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment, 3 to 11 Years</i>	37.3%	45.7%	★★★★	+8.4
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment, 12 to 17 Years</i>	38.8%	48.2%	★★★★	+9.4
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment, Total</i>	37.8%	46.6%	★★★★	+8.8
<i>Appropriate Treatment for Children With Upper Respiratory Infection (URI)</i>	82.3%	84.9%	★★	+2.6
<i>Appropriate Testing for Children With Pharyngitis</i>	51.9%	54.9%	★★	+3.0
Women’s and Adult Care				
<i>Breast Cancer Screening</i>	55.1%	56.3%	★★★	+1.2
<i>Cervical Cancer Screening</i>	72.7%	74.3%	★★★★	+1.6
<i>Chlamydia Screening in Women—16 to 20 Years</i>	61.1%	60.7%	★★★	-0.4
<i>Chlamydia Screening in Women—21 to 24 Years</i>	67.8%	68.4%	★★★	+0.6
<i>Chlamydia Screening in Women—Combined</i>	63.5%	63.5%	★★★	0.0
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	88.9%	88.4%	★★★	-0.5
<i>Prenatal and Postpartum Care—Postpartum Care</i>	71.4%	70.7%	★★★★	-0.7
<i>Adult BMI Assessment</i>	47.7%	63.0%	★★★★★	+15.3
2010–2011 comparison note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decrease from the prior year.				
★★★★★	=	90th percentile and above		
★★★★	=	75th to 89th percentile		
★★★	=	50th to 74th percentile		
★★	=	25th to 49th percentile		
★	=	Below 25th percentile		

Table 3-1—Overall Statewide Weighted Averages for Performance Measures

Performance Measure	2010 MI Medicaid	2011 MI Medicaid	Performance Level for 2011	2010–2011 Comparison
Living With Illness				
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	83.9%	85.0%	★★★	+1.1
<i>Comprehensive Diabetes Care—Poor HbA1c Control*</i>	35.6%	36.4%	★★★	+0.8
<i>Comprehensive Diabetes Care—Eye Exam</i>	59.6%	59.0%	★★★	-0.6
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	80.1%	80.8%	★★★★	+0.7
<i>Comprehensive Diabetes Care—LDL-C Level <100 mg/dL</i>	39.0%	41.1%	★★★★	+2.1
<i>Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy</i>	82.4%	82.8%	★★★★	+0.4
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/80 mm Hg)[^]</i>	†	40.8%	†	—
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	60.1%	63.7%	★★★	+3.6
<i>Use of Appropriate Medications for People With Asthma—5 to 11 Years</i>	90.4%	91.4%	★★	+1.0
<i>Use of Appropriate Medications for People With Asthma—12 to 50 Years</i>	84.8%	85.2%	★★	+0.4
<i>Use of Appropriate Medications for People With Asthma—Combined Rate</i>	86.8%	87.4%	★★	+0.6
<i>Controlling High Blood Pressure</i>	59.8%	61.5%	★★★	+1.7
<i>Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers to Quit</i>	76.9%	78.2%	❖	+1.3
<i>Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications</i>	47.7%	48.8%	❖	+1.1
<i>Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies</i>	40.4%	41.3%	❖	+0.9
Access to Care				
<i>Children’s Access to Primary Care Practitioners—12 to 24 Months</i>	96.7%	96.7%	★★	0.0
<i>Children’s Access to Primary Care Practitioners—25 Months to 6 Years</i>	88.8%	89.8%	★★★	+1.0
<i>Children’s Access to Primary Care Practitioners—7 to 11 Years</i>	89.1%	91.1%	★★	+2.0
<i>Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i>	87.0%	89.5%	★★★	+2.5
<i>Adults’ Access to Preventive/Ambulatory Health Services—20 to 44 Years</i>	83.0%	83.2%	★★★	+0.2
<i>Adults’ Access to Preventive/Ambulatory Health Services—45 to 64 Years</i>	88.8%	89.1%	★★★	+0.3
<i>Adults’ Access to Preventive/Ambulatory Health Services—65+ Years</i>	92.6%	89.1%	★★★	-3.5
<i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i>	84.8%	85.0%	★★★	+0.2
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months[†]</i>	319.3	316.9	★	-2.4
<i>Ambulatory Care—ED Visits per 1,000 Member Months[†]</i>	72.2	69.6	★★★	-2.6

* For this measure, a lower rate indicates better performance.

[^] During HEDIS 2011, this indicator was changed from *Blood Pressure Control <130/80* to *Blood Pressure Control <140/80*.

[†] Due to changes to the measure specifications for this indicator, results are not comparable to the previous year’s rate and national benchmarks are not available for this measurement period.

❖ These measures are CAHPS measures; therefore, no HEDIS benchmarks are available.

[†] For Ambulatory Care measures, the statewide rates represent straight averages, not weighted averages.

- ★★★★★ = 90th percentile and above
- ★★★★ = 75th to 89th percentile
- ★★★ = 50th to 74th percentile
- ★★ = 25th to 49th percentile
- ★ = Below 25th percentile

The HEDIS 2011 average rates for 33 of the 44 measures that could be compared to prior-year performance showed an increase, with 13 of these increases reaching statistical significance. Rates for nine measures declined and rates for two measures remained unchanged from the 2010 results. Increases in rate ranged from less than 1 percentage point to over 15 percentage points, while most decreases were less than 1 percentage point.

The Pediatric and Adolescent Care dimension showed more improvement than the other dimensions, with all but one of the 12 measures showing an increase in the rate and seven measures noting statistically significant increases from the prior year. The *Lead Screening in Children* measure improved the most in this dimension, showing an 11.9 percentage point increase from the prior year. Measures in the Living With Illness dimension showed small increases in almost all measures and had one measure—*Comprehensive Diabetes Care—Blood Pressure Control (<140/90)*—that reflected a statistically significant improvement. The measure with the largest improvement was found within the Women’s and Adult Care dimension, where the *Adult BMI Assessment* measure improved by 15.3 percentage points from the prior year.

While none of the measures had statistically significant decreases, the Women’s and Adult Care and Access to Care dimensions were notable for the number of measures that showed a decrease in performance. For the Women’s and Adult Care dimension, those measures were *Chlamydia Screening in Women—16 to 20 years*, *Timeliness of Prenatal Care*, and *Postpartum Care*, with rates declining by less than 1 percentage point. For the Access to Care dimension, decreased rates were noted for *Adults’ Access to Preventive/Ambulatory Health Services—65+Years*, *Ambulatory Care—Outpatient Visits per 1,000 Member Months*, and *Ambulatory Care—ED Visits per 1,000 Member Months*. These measures declined by 2.4 to 3.5 percentage points from their prior-year rate.

Table 3-2 presents the number of MHPs with performance measure rates in each of the percentile categories. The results shown in this table exclude any measures with an *NA (Not Applicable)* audit finding. The results for some measures were calculated based on 13 rather than 14 plans because one MHP did not have sufficient sample sizes to report the rates.

Table 3-2—Distribution of MHP Performance Compared With National Medicaid Benchmarks					
Performance Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Pediatric and Adolescent Care					
<i>Childhood Immunization Status—Combination 2</i>	1	3	5	2	3
<i>Childhood Immunization Status—Combination 3</i>	1	3	5	2	3
<i>Immunizations for Adolescents</i>	0	1	1	5	6
<i>Lead Screening in Children</i>	1	1	8	3	1
<i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>	2	3	1	3	5
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	2	2	5	3	2
<i>Adolescent Well-Care Visits</i>	1	0	4	6	3
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment, 3 to 11 Years</i>	0	1	6	4	3
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment, 12 to 17 Years</i>	0	0	5	5	3
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment, Total</i>	0	1	6	4	3
<i>Appropriate Treatment for Children With Upper Respiratory Infection (URI)</i>	2	4	5	1	1
<i>Appropriate Testing for Children With Pharyngitis</i>	7	3	2	0	1
Women’s and Adult Care					
<i>Breast Cancer Screening</i>	1	1	7	3	1
<i>Cervical Cancer Screening</i>	1	1	4	7	1
<i>Chlamydia Screening in Women—16 to 20 Years</i>	1	2	6	1	3
<i>Chlamydia Screening in Women—21 to 24 Years</i>	0	2	6	3	2
<i>Chlamydia Screening in Women—Combined</i>	0	2	7	3	2
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	1	3	3	3	3
<i>Prenatal and Postpartum Care—Postpartum Care</i>	1	2	5	1	4
<i>Adult BMI Assessment</i>	0	0	1	4	9
★★★★★	=	90th percentile and above			
★★★★	=	75th to 89th percentile			
★★★	=	50th to 74th percentile			
★★	=	25th to 49th percentile			
★	=	Below 25th percentile			

Table 3-2—Distribution of MHP Performance Compared With National Medicaid Benchmarks

Performance Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Living With Illness					
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	0	2	5	3	4
<i>Comprehensive Diabetes Care—Poor HbA1c Control*</i>	0	2	7	3	2
<i>Comprehensive Diabetes Care—Eye Exam</i>	1	3	5	2	3
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	1	2	4	3	4
<i>Comprehensive Diabetes Care—LDL-C Level <100mg/dL</i>	0	1	6	4	3
<i>Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy</i>	0	2	3	4	5
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/80 mm Hg)^</i>	†	†	†	†	†
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	0	4	6	2	2
<i>Use of Appropriate Medications for People With Asthma—5 to 11 Years</i>	3	0	5	3	2
<i>Use of Appropriate Medications for People With Asthma—12 to 50 Years</i>	3	1	6	0	3
<i>Use of Appropriate Medications for People With Asthma—Combined Rate</i>	3	1	5	2	2
<i>Controlling High Blood Pressure</i>	2	2	4	4	2
<i>Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers to Quit</i>	❖	❖	❖	❖	❖
<i>Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications</i>	❖	❖	❖	❖	❖
<i>Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies</i>	❖	❖	❖	❖	❖

* For this measure, a lower rate indicates better performance.

^ During HEDIS 2011, this indicator was changed from *Blood Pressure Control <130/80* to *Blood Pressure Control <140/80*.

† Due to changes to the measure specifications for this indicator, national benchmarks are not available for this measurement period.

❖ These measures are CAHPS measures; therefore, no HEDIS benchmarks are available.

- ★★★★★ = 90th percentile and above
- ★★★★ = 75th to 89th percentile
- ★★★ = 50th to 74th percentile
- ★★ = 25th to 49th percentile
- ★ = Below 25th percentile

Table 3-2—Distribution of MHP Performance Compared With National Medicaid Benchmarks

Performance Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Access to Care					
<i>Children’s Access to Primary Care Practitioners—12 to 24 Months</i>	5	2	4	2	1
<i>Children’s Access to Primary Care Practitioners—25 Months to 6 Years</i>	6	1	6	0	1
<i>Children’s Access to Primary Care Practitioners—7 to 11 Years</i>	2	6	2	3	0
<i>Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i>	2	6	2	4	0
<i>Adults’ Access to Preventive/Ambulatory Health Services—20 to 44 Years</i>	2	5	5	1	1
<i>Adults’ Access to Preventive/Ambulatory Health Services—45 to 64 Years</i>	1	5	3	4	1
<i>Adults’ Access to Preventive/Ambulatory Health Services—65+ Years</i>	0	0	2	2	0
<i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i>	2	4	6	1	1
<i>Ambulatory Care—Outpatient Visits Total</i>	2	4	6	1	1
<i>Ambulatory Care—ED Visits Total</i>	0	5	8	1	0
Total	57	93	192	112	97
★★★★★	= 90th percentile and above				
★★★★	= 75th to 89th percentile				
★★★	= 50th to 74th percentile				
★★	= 25th to 49th percentile				
★	= Below 25th percentile				

Table 3-2 shows that 34.8 percent of all performance measure rates (192 of 551) fell into the average (★★★) range relative to national Medicaid results. While 17.6 percent of all performance measure rates ranked in the 90th percentile and above (★★★★★), 27.2 percent of all performance measure rates fell below the national Medicaid HEDIS 2010 50th percentile, providing opportunities for improvement.

Statewide performance was strongest in the Women’s and Adult Care dimension, with the highest percentage (23.4 percent) of measures performing at or above the 90th percentile, as well as the lowest percentage of rates falling below the national Medicaid HEDIS 2010 50th percentile. The MHP showed strong performance in the Pediatric and Adolescent Care dimension with 20.7 percent of measures ranking at or above the 90th percentile. Conversely, Access to Care was the poorest performing dimension, with only 4.7 percent of the performance measure rates ranking at or above the 90th percentile. This dimension represented the largest opportunity for improvement with 46.5 percent of the rates ranking below the national 50th percentile.

Performance Improvement Projects (PIPs)

Table 3-3 presents a summary of the MHPs’ PIP validation status results. All PIPs submitted for the 2010–2011 validation focused on the new State-selected topic, *Childhood Obesity*. For the 2010–2011 validation, all PIPs received a validation status of *Met*, reflecting continued strong performance.

Table 3-3—MHPs’ PIP Validation Status		
Validation Status	Percentage of PIPs	
	2009–2010	2010–2011
<i>Met</i>	100%	100%
<i>Partially Met</i>	0%	0%
<i>Not Met</i>	0%	0%

The following presents a summary of the validation results for the MHPs for each of the ten activities from the CMS PIP protocol. All first-year PIPs progressed through Activity VIII, Implement Intervention and Improvement Strategies.

Table 3-4 shows the percentage of MHPs that met all of the applicable evaluation or critical elements within each of the ten activities.

Table 3-4—Summary of Data From Validation of Performance Improvement Projects			
Review Activities		Percentage Meeting all Elements/ Percentage Meeting All Critical Elements	
		2009–2010	2010–2011
I.	Select the Study Topic(s)	93%/100%	100%/100%
II.	Define the Study Question(s)	100%/100%	100%/100%
III.	Select the Study Indicator(s)	100%/100%	100%/100%
IV.	Use a Representative and Generalizable Study Population	100%/100%	100%/100%
V.	Use Sound Sampling Techniques*	100%/100%	92%/100%
VI.	Reliably Collect Data	93%/100%	93%/100%
VII.	Analyze Data and Interpret Study Results	100%/100%	93%/100%
VIII.	Implement Intervention and Improvement Strategies	64%/100%	100%/100%
IX.	Assess for Real Improvement	17%/NCE	Not Assessed
X.	Assess for Sustained Improvement	30%/NCE	Not Assessed

NCE = No Critical Elements * This activity is assessed only for PIPs that conduct sampling.

All 14 MHPs received scores of *Fully Compliant* for each applicable critical element across all activities and achieved compliance with almost all evaluation elements. Twelve of the PIPs met all applicable evaluation and critical elements. One PIP failed to demonstrate full compliance with only one element, and another PIP partially met one element for two separate activities.

The MHPs continued to demonstrate high levels of compliance with the requirements of the CMS PIP protocol for activities related to the study topic, study question, study indicator, study population, and interventions and improvement strategies. The percentages of MHPs meeting all evaluation elements remained high for the activities related to sampling techniques, data collection procedures, and data analysis. The 2010–2011 validation did not identify any statewide opportunities for improvement.

Conclusions/Summary

The review of the MHPs showed both strengths and opportunities for improvement statewide.

Results of the annual compliance reviews reflected improved performance. The MHPs, for the most part, successfully addressed recommendations from the 2009–2010 compliance review cycle and demonstrated compliance with contractual requirements. Statewide opportunities for improvement were identified for the *Quality/Utilization*; *MIS/Data Reporting/Claims Processing*; and *Fraud, Waste, and Abuse* standards.

The MHPs demonstrated mostly average to above-average performance across the performance measures compared with national Medicaid HEDIS 2010 results. Compared with the prior-year Michigan statewide rates, 30 of the 41 comparable measures reflected improved performance. These rates included 11 of the 12 measures in the Pediatric and Adolescent Care dimension, with seven of the increases reaching statistical significance. MHP performance in this dimension represented a statewide strength. Most of the measures in the Living With Illness dimension showed improvement. Statewide performance in the Women’s and Adult Care dimension remained relatively unchanged from the prior year, with the exception of the rate for *Adult BMI Assessment*, which showed a large, statistically significant increase. The rates for most measures in the *Access to Care* dimension increased over the 2010 rates; however, this dimension remained an opportunity for improvement.

The 2010–2011 validation of the PIPs reflected high levels of compliance with the requirements of the CMS PIP protocol for the first eight activities. All 14 PIPs received a validation status of *Met*, indicating that the PIPs were designed in a methodologically sound manner, giving confidence that the PIPs produced valid and reliable results.